Nursing Facility Transitions Policy and Procedure Workgroup Minutes

January 22, 2008, 1pm to 5 (Doublewood Inn, Bismarck
January 23, 2008 9 am to Noon (Doublewood Inn, Bismarck)

Documents Provided/Reviewed: Revised Nursing Facility Transition Process, , Revised ND MFP Role Matrix, Revised ND Draft Independent Living Plan, Revised MFP Referral Form, Texas Informed Consent and Guardianship Protocol, Workgroup meeting minutes from 1/7/08 and 1/8/08 meeting, Person Center Planning information.

Workgroup Members Present: Judie Lee, IPAT, Sandy Arends, SEHSC Aging Services, Gwen Beckler, Dakota Center for Independent Living, Bruce Murry, ND P &A, Sharon Klein, Missouri Slope Lutheran Care Center, Meredith Baumann Valley Eldercare Center, Mary Devlin, Dakota Central Social Services District, Diane Mortenson, Stark County Social Services, Royce Schultze, Dakota Center for Independent Living, Susan Ogurek, Independence Inc, LaRae Gustafson, Options CIL, Helen Funk, DHS Ombudsman, Colette Mund, Burleigh County Social Services, Rhonda Heartfield Bismarck Senior Center, D'Ette Ruggels Mark Bourdon, Freedom Resource Center, Jake Reuter, MFP Grant Manger, DHS, Medical Services, Delana Duffy-Aziz, Cass County Social Services

1. Nursing Facility Transition Process was reviewed by the workgroup with the following discussion noted:
    - Step 1-MFP Grant Manager will notify Transition Coordinators and Nursing Facility Social Services staff of MFP eligible individuals by e-mail or letter-Jake will check with Privacy Officer about e-mail privacy issues
    - Step 2-Questions raised related to what can we reasonably expect the NF social services staff to do to make their resident aware of the MFP process-what information do they need to have to give to their residents before the meeting with the Transition Coordinator?
    - Step 2-It was agreed that a brochure outlining the grant would be the most helpful information for the consumer/resident to have prior to the first meeting. This will be reflected in the process.
    - Step 2- We will need to educate all NF social work staff about this process. The LTC newsletter will be one method to accomplish this goal. Jake will also need to provide the information to the NF staff prior to the start of transitioning. The transition staff could also provide education in regional meetings or individual meetings with NF Staff
    - Step 3-It was noted that this meeting may take more than one visit due to the amount of information that will be provided related to MFP and the CIL process.

- Step 3- MFP will have a specific rights brochure to be given to the consumer
- Step 3-Consumers will receive information on CAP and the Administrative appeals process
- Step 3-The HCBS Case Manager will be the contact at this time with eligibility issues discussed with the eligibility worker and support services in the area discussed with the HCBS CM as the situation seem appropriate. The need to assure continued eligibility is key at this stage in the process
- Step 4-Noted that any consumer reports of Abuse or Neglect to the TC will be forwarded to the Ombudsman or Protection and Advocacy staff depending on the individual.
- Step 5-The HCBS Case Manager will be invited to participate in the review of the consumers support needs during the transition/discharge planning meeting. This team will be considered the core planning team.
- Step 6-Need to utilize a Person Centered planning process
- Step 6-The team will be responsible to request additional screenings and/or referrals as the consumer needs i.e. IPAT, OT, PT, accessibility assessment etc. to assure all support needs are considered and services are made available to meet those needs.
- Step 6-The IPAT screen tool would be used for all IPAT screenings completed and will be forwarded to the Fargo office for review.
- Step 6-Will need to identify ways to address a consumers choice not to develop formal plans as part of their rights to “waive goal development”
- Step 7-Supplemental Service requests maybe appropriate at this time and these will be forwarded to MFP Grant Manager after they are prepared by the Transition Coordinator
- Step 8-CIL staff may not have to complete the initial Quality of Life Survey if an alternative option is identified
- Step 9- Core team will meet at this time in the process to plan for final detail of the transition. Home visits were clarified to mean attending appointments in the community to do things like apply for food stamps, visiting the housing office etc.
- Step 9 or 10- the Risk Mitigation plan and 24 hour backup plans will need to be developed prior to transition to the community.
- Step 10-HCBS Case Manager should be preparing care plan to authorize support services
- Step 10-RE-Screening will need to be completed with 2-3 weeks of transition to the community-Will need to work with NF social services to get this completed

- Step 11-No changes
- Step 12-The Independent Living Plan will need to be updated to reflect the new goals of the consumer after the transition to the community. The new goals will be added to existing plan
- Step 12-HCBS Case Manger will be making a home visit and will revise the care plan as that maybe necessary.
- Step 12-The Transition Coordinator and HCBS Case Manger will be working together at this time to support the success of the transition
- Step 12-The Transition Coordinator will be the take the leadership role as they will have the most consistent contact with the consumer
- Transitional Coordinator will continue to update the Independent Living Plan over the one year after transition. Will keep goals and responsibilities of service providers clear in this plan

2. The draft Independent Living Plan document was reviewed with the following issues noted:
    - The goal areas of the plan are now paired with the findings of the assessment for to assure that each support need is addressed. Example: Section 4: Self Care (Assessment Area A.1-15) referenced from the transition assessment. The scores from the assessment will be reference on the Independent Living Plan to provide information on support needs

    - The Planning sections were rearranged to read as follows:
        a. Relocation
        b. Strengths and Barriers
        c. Self Advocacy/Self-Empowerment
        d. Self care/ADLs
        e. Instrumental Activities of Daily Living
        f. Special Needs
        g. Community Based Living
        h. Community/Social Participation
        i. Mobility/Transportation
        j. Personal Resource Management
        k. Communication (Receptive and Expressive)
        l. Information Access/Assistive Technology/Equipment
        m. Vocational/Volunteering
        n. Education
        o. Risk Mitigation Plan
        p. Backup Plan
        q. Signature Page

The goal areas were generated from the areas required of the Centers for Independent Living outlined in Federal guidelines

- The draft questions were reviewed and it was agreed that too many checkboxes will be intimidating and counterproductive. Two questions see reasonable including: I am aware that I will be giving up my nursing facility bed at the time of discharge and I am in agreement with the Independent Living Plan
- The Independent Living Plan will be completed using a state e-form so that its size will be adjustable and specific to each consumer specific goals.
- The question of the grant purchasing laptop computer was raised-CMS will be contacted about this possibility.

3. The risk mitigation plan was reviewed with the following issues discussed:
    - Risk mitigation assessment and planning is a quality assurance requirement of the MFP Grant
    - The need to respect consumer choice is crucial to any risk mitigation process
    - The areas of risk are assessed by the Transition Coordinator and the finding are refereed on the Risk Mitigation Plan
      Example: Substance Abuse (Assessment Area 7. A. 3-5) Yes or No and Risk Mitigation steps outline by the consumer and the core team
    - Fire Safety will be used instead of smoking
    - If the risk area is not of concern to either the consumer of the core team the risk mitigation steps will not be outlined
    - Critical Incidents will be included in risk mitigation due to the limited oversight of the Independent Qualified Services providers and tendency of the consumers not to report issues of concern.
4. The MFP requirement for 24 hour backup services was reviewed and the Quality Assurance workgroup's recommendation that each consumer develop an individualized back plan was discussed.
    - A backup plan format will need to be developed for use by the consumer and the core team prior to and after transition.
    - Backup plans will utilize area services that can meet the needs of the consumer to address critical health and welfare issues
    - A 24 hour nurse call service will be developed for all MFP participants to use but the nursing service will utilize the contacts and services developed and provided by the core team.

- Sue Oguek will provide a form that maybe helpful in developing the teams develop the backup plans
- The backup plan will need to be completed and set to the nursing service prior to discharge so that it is available on the first day of transition
- Generic Services when possible and when QSP
- Culture of Provider Responsibility & Self Directed Care/Responsibility
- Care plan needs to include all potential providers
- 911, 211, lifeline, P&A 24 hr line; VIAL of life (document);
- See Sue, Independence will share a document re backups

5. The Role Matrix document was reviewed with the following recommendation made:
    - Ariel font will be utilized in the document
    - A large Print format will need to be made available in 16 front
    - Under Nursing Facility staff it was recommended that we add that if someone does not qualify for the MFP Grant they should be referred to a CIL for assistance with their transition
    - Under HCBS Case Manger the need to assure that a new NF screening is completed prior to discharge will be added.
6. The Nursing Facility Transition Referral document was found to be complete in its form.
7. MFP participants re-institutionalized great than 30 days are deemed as disenrolled from the MFP grant program. It was agreed that a former MFP participant may re-enroll in the program after undergoing and reevaluation and after development of a new Independent Living Plan. The Transitional Coordinator will update the Transition Assessment and the Independent Living Plan with the appropriate team to reflect the current support needs of the consumer.
8. Short term stay notification to the county Medicaid eligibility worker is essential to allow consumer/residents to keep their home for the first 6 months of their admission or during times a consumer returns to a nursing home for care after living in the community.
    - Letters of notification offered by Meredith Baumann, Social Worker of Valley Eldercare Center were reviewed. It was agree that more education is needed for nursing facility social worker to help preserve the home and assessments of short term residents. This will be done through the ND LTC newsletter and regional meetings.

- Transition Coordinators can use these same forms for consumers that return for a short term nursing facility after their initial transition.
- Transitional Coordinators could check with NF staff after the consumer returns to the NF to see if the notification was made
- This would also be good information for hospital discharge planners

9. It was agreed that the HCBS case manager will be provided with a written copy of the Transition Assessment by the Transition Coordinator. Electronic access was also requested and will be explored as it will improve the process. It was also noted that lack of information is a real barrier to good care.
10. It recommended that hospital discharge planners be provided with information about the MFP grant and the Transition Coordination services. The MFP brochure will be useful for this purpose as would a fact sheet with 3-5 bullet points.
11. Marketing/Education/Outreach -Strategies
    - Brochures
    - Word of Mouth
    - MFP Fact sheet
    - Presentation to groups like Senior Sensation, Forum on Aging, Governors' Commission on Aging, Long Term Care Association, and Regional Counsel's on Aging
    - Provide information to HCBS Case Managers at regional meetings and annual training
    - Use quarterly HCBS newsletter for education
    - Use Regional Aging Services Newsletter for education
    - NASW
    - LTC Social Worker-newsletter and membership meetings
    - LTC convention-Information booth

12. Concerns about Qualified Service Providers were discussed including:
    - Need more QSP to provide care
    - No training is provided to QSPs
    - Little accountability for QSPs
    - QSPs are independent Providers and need education and support to get backup if they are ill
    - Payment barrier in the system does not allow payment for QSPs not on the consumers provider list
    - Need to educate QSPs about critical incidents and their need report them to the HCBS Case Manager

13. Person Centered Planning was reviewed including the DD Person Centered Planning process document and information on PCP from the Michigan CIL system. Susan Oguek agreed to review this information and prepare a document to be used for the Operational Protocol and in educating the planning teams.
14. The Texas Informed Consent and Guardianship protocol was reviewed. The need to complete an informed consent, provide a copy of MFP Rights, and address guardian involvement was reviewed. Bruce Murry agreed to review these documents and protocol and offer a draft protocol and consent document for review by the workgroup.
15. Plans:
    - Meredith and LaRae will update the NF Transition Process Outline
    - Sue and Meredith will prepare the MFP Brochure
    - Sue will work on the Person Centered Planning Document
    - Bruce will be work on the consent and guardianship protocol and form
    - Sue will provide information on the backup plan information that will be needed by the core planning teams
    - Jake will prepare the Operational Protocol for review by the workgroup
    - Training manual for the Transition Assessment will be prepared by Jake

16. Brochure Content

- Mission of MFP
- Eligibility Criteria
- Four Goals of the grant
- Contact People (agencies) – 4 CIL TCs, Jake, etc.,
    - Roles of these people
- Website on brochure
- One brochure with numbers for the regions
- (Perhaps bi-fold rather than tri-fold?)
- (Shoot for 5th to 6th grade reading level?)
- Transition DC & NF to community

Target Populations for Brochure and Education

- Consumers
- Family Members/Alternative Decision Makers/Legal Decision Makers
- Providers/Agencies
    - NF
    - HCBS
    - Hospitals
    - NDACF
    - HSC
    - Pub Health
    - Parish Nurses
    - Home Health
    - DME Vendors
    - Senior Centers
    - Hosp & Clinic

Education on MFP:

WHO	WHAT	HOW
NF Spring Mtg		
NF Admin		
NF Social Workers & designees		
HCBS		
ADR Line & 211		
DDCM		
Legal Svcs ND		

CIL Transition Coordinators	Assessment (website, manual &or handbook) (JR) IL Process, Grant-Overview, Process & Forms, AT overview, P&A, compare definitions person centered planning	
Ombudsman		
Hospital Discharge Planners		
NDACF Providers		
SDC Staff		
HCBS April Conference		
P&A Inservice		
Council on Aging (Dick'n)		
Regional Aging Svcs Admin		
IPAT Consumer Advis		
AARP		
NDDAC		
Volunteer Ombudsman, Oct		October conference
Sr Sensation Ramkota		
Forum on Aging		
Graying of ND		
Conference Social W'fare		
Center for Persons with Disabilities? (by Bruce)		

BARRIER: Requirement that provider in question be on the care plan! Also the individual must give written consent to add the new QSP. Possible solution: list of all alternative QSPs on plan up front

17. Next Meeting is set for 3-26 &27-2008 in Bismarck